



General Assembly

January Session, 2017

Amendment

LCO No. 7905



Offered by:

SEN. LARSON, 3rd Dist.

REP. SCANLON, 98th Dist.

To: Subst. Senate Bill No. 807

File No. 244

Cal. No. 148

"AN ACT INCREASING THE MINIMUM NET WORTH OF AND SECURITY MAINTAINED BY PREFERRED PROVIDER NETWORKS, AND MAKING MINOR AND TECHNICAL CHANGES TO CERTAIN INSURANCE-RELATED STATUTES."

1 After the last section, add the following and renumber sections and
2 internal references accordingly:

3 "Sec. 501. Section 19a-7p of the general statutes is repealed and the
4 following is substituted in lieu thereof (*Effective from passage and*
5 *applicable to any public health fee due on or after February 1, 2017*):

6 (a) Not later than September first, annually, the Secretary of the
7 Office of Policy and Management, in consultation with the
8 Commissioner of Public Health, shall (1) determine the amounts
9 appropriated for the needle and syringe exchange program, AIDS
10 services, breast and cervical cancer detection and treatment, x-ray
11 screening and tuberculosis care, and venereal disease control; and (2)
12 inform the Insurance Commissioner of such amounts.

13 (b) (1) As used in this section: (A) "Health insurance" means health
14 insurance of the types specified in subdivisions (1), (2), (4), (11) and
15 (12) of section 38a-469; and (B) "health care center" has the same
16 meaning as provided in section 38a-175.

17 (2) Each domestic insurer or domestic health care center doing
18 health insurance business in this state shall annually pay to the
19 Insurance Commissioner, for deposit in the Insurance Fund
20 established under section 38a-52a, a public health fee assessed by the
21 Insurance Commissioner pursuant to this section.

22 (3) Not later than September first, annually, each such insurer or
23 health care center shall report to the Insurance Commissioner, in the
24 form and manner prescribed by said commissioner, the number of
25 insured or enrolled lives in this state as of May first immediately
26 preceding the date for which such insurer or health care center is
27 providing health insurance that provides coverage of the types
28 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469.
29 Such number shall not include lives enrolled in Medicare, any medical
30 assistance program administered by the Department of Social Services,
31 workers' compensation insurance or Medicare Part C plans.

32 (c) Not later than November first, annually, the Insurance
33 Commissioner shall determine the fee to be assessed for the current
34 fiscal year against each such insurer and health care center. Such fee
35 shall be calculated by multiplying the number of lives reported to said
36 commissioner pursuant to subdivision (3) of subsection (b) of this
37 section by a factor, determined annually by said commissioner as set
38 forth in this subsection, to fully fund the aggregate amount determined
39 under subsection (a) of this section. The Insurance Commissioner shall
40 determine the factor by dividing the aggregate amount by the total
41 number of lives reported to said commissioner pursuant to subdivision
42 (3) of subsection (b) of this section.

43 (d) Not later than December first, annually, the Insurance
44 Commissioner shall submit a statement to each such insurer and health

45 care center that includes the proposed fee, identified on such statement
46 as the "Public Health fee", for the insurer or health care center,
47 calculated in accordance with this section. Not later than December
48 twentieth, annually, any insurer or health care center may submit an
49 objection to the Insurance Commissioner concerning the proposed
50 public health fee. The Insurance Commissioner, after making any
51 adjustment that said commissioner deems necessary, shall, not later
52 than January first, annually, submit a final statement to each insurer
53 and health care center that includes the final fee for the insurer or
54 health care center. Each such insurer and health care center shall pay
55 such fee to the Insurance Commissioner not later than February first,
56 annually.

57 (e) Any such insurer or health care center aggrieved by an
58 assessment levied under this section may appeal therefrom in the same
59 manner as provided for appeals under section 38a-52.

60 (f) (1) The Insurance Commissioner shall apply an overpayment of
61 the public health fee by an insurer or health care center for any fiscal
62 year as a credit against the public health fee due from such insurer or
63 health care center for the succeeding fiscal year, subject to an
64 adjustment under subsection (c) of this section, if: (A) The amount of
65 the overpayment exceeds five thousand dollars; and (B) on or before
66 June first of the calendar year of the overpayment, the insurer or health
67 care center (i) notifies the commissioner of the amount of the
68 overpayment, and (ii) provides the commissioner with evidence
69 sufficient to prove the amount of the overpayment.

70 (2) Not later than ninety days following receipt of notice and
71 supporting evidence under subdivision (1) of this subsection, the
72 commissioner shall (A) determine whether the insurer or health care
73 center made an overpayment, and (B) notify the insurer or health care
74 center of such determination.

75 (3) Failure of an insurer or health care center to notify the
76 commissioner of the amount of an overpayment within the time

77 prescribed in subdivision (1) of this subsection constitutes a waiver of
78 any demand of the insurer or health care center against the state on
79 account of such overpayment.

80 (4) Nothing in this subsection shall be construed to prohibit or limit
81 the right of an insurer or health care center to appeal pursuant to
82 subsection (e) of this section.

83 Sec. 502. Section 19a-7j of the general statutes is repealed and the
84 following is substituted in lieu thereof (*Effective from passage and*
85 *applicable to any health and welfare fee due on or after February 1, 2017*):

86 (a) Not later than September first, annually, the Secretary of the
87 Office of Policy and Management, in consultation with the
88 Commissioner of Public Health, shall (1) determine the amount
89 appropriated for the following purposes: (A) To purchase, store and
90 distribute vaccines for routine immunizations included in the schedule
91 for active immunization required by section 19a-7f; (B) to purchase,
92 store and distribute (i) vaccines to prevent hepatitis A and B in persons
93 of all ages, as recommended by the schedule for immunizations
94 published by the National Advisory Committee for Immunization
95 Practices, (ii) antibiotics necessary for the treatment of tuberculosis and
96 biologics and antibiotics necessary for the detection and treatment of
97 tuberculosis infections, and (iii) antibiotics to support treatment of
98 patients in communicable disease control clinics, as defined in section
99 19a-216a; (C) to administer the immunization program described in
100 section 19a-7f; and (D) to provide services needed to collect up-to-date
101 information on childhood immunizations for all children enrolled in
102 Medicaid who reach two years of age during the year preceding the
103 current fiscal year, to incorporate such information into the childhood
104 immunization registry, as defined in section 19a-7h, (2) calculate the
105 difference between the amount expended in the prior fiscal year for the
106 purposes set forth in subdivision (1) of this subsection and the amount
107 of the appropriation used for the purpose of the health and welfare fee
108 established in subparagraph (A) of subdivision (2) of subsection (b) of
109 this section in that same year, and (3) inform the Insurance

110 Commissioner of such amounts.

111 (b) (1) As used in this subsection, (A) "health insurance" means
112 health insurance of the types specified in subdivisions (1), (2), (4), (11)
113 and (12) of section 38a-469, and (B) "exempt insurer" means a domestic
114 insurer that administers self-insured health benefit plans and is exempt
115 from third-party administrator licensure under subparagraph (C) of
116 subdivision (11) of section 38a-720 and section 38a-720a.

117 (2) (A) Each domestic insurer or domestic health care center doing
118 health insurance business in this state shall annually pay to the
119 Insurance Commissioner, for deposit in the Insurance Fund
120 established under section 38a-52a, a health and welfare fee assessed by
121 the Insurance Commissioner pursuant to this section.

122 (B) Each third-party administrator licensed pursuant to section 38a-
123 720a that provides administrative services for self-insured health
124 benefit plans and each exempt insurer shall, on behalf of the self-
125 insured health benefit plans for which such third-party administrator
126 or exempt insurer provides administrative services, annually pay to
127 the Insurance Commissioner, for deposit in the Insurance Fund
128 established under section 38a-52a, a health and welfare fee assessed by
129 the Insurance Commissioner pursuant to this section.

130 (3) Not later than September first, annually, each such insurer,
131 health care center, third-party administrator and exempt insurer shall
132 report to the Insurance Commissioner, on a form designated by said
133 commissioner, the number of insured or enrolled lives in this state as
134 of May first immediately preceding for which such insurer, health care
135 center, third-party administrator or exempt insurer is providing health
136 insurance or administering a self-insured health benefit plan that
137 provides coverage of the types specified in subdivisions (1), (2), (4),
138 (11) and (12) of section 38a-469. Such number shall not include lives
139 enrolled in Medicare, any medical assistance program administered by
140 the Department of Social Services, workers' compensation insurance or
141 Medicare Part C plans.

142 (4) Not later than November first, annually, the Insurance
143 Commissioner shall determine the fee to be assessed for the current
144 fiscal year against each such insurer, health care center, third-party
145 administrator and exempt insurer. Such fee shall be calculated by
146 multiplying the number of lives reported to said commissioner
147 pursuant to subdivision (3) of this subsection by a factor, determined
148 annually by said commissioner as set forth in this subdivision, to fully
149 fund the amount determined under subsection (a) of this section,
150 adjusted for a health and welfare fee, by subtracting, if the amount
151 appropriated was more than the amount expended or by adding, if the
152 amount expended was more than the amount appropriated, the
153 amount calculated under subdivision (2) of subsection (a) of this
154 section. The Insurance Commissioner shall determine the factor by
155 dividing the adjusted amount by the total number of lives reported to
156 said commissioner pursuant to subdivision (3) of this subsection.

157 (5) (A) Not later than December first, annually, the Insurance
158 Commissioner shall submit a statement to each such insurer, health
159 care center, third-party administrator and exempt insurer that includes
160 the proposed fee, identified on such statement as the "Health and
161 Welfare fee", for the insurer, health care center, third-party
162 administrator or exempt insurer calculated in accordance with this
163 subsection. Each such insurer, health care center, third-party
164 administrator and exempt insurer shall pay such fee to the Insurance
165 Commissioner not later than February first, annually.

166 (B) Any such insurer, health care center, third-party administrator
167 or exempt insurer aggrieved by an assessment levied under this
168 subsection may appeal therefrom in the same manner as provided for
169 appeals under section 38a-52.

170 (6) Any insurer, health care center, third-party administrator or
171 exempt insurer that fails to file the report required under subdivision
172 (3) of this subsection shall pay a late filing fee of one hundred dollars
173 per day for each day from the date such report was due. The Insurance
174 Commissioner may require an insurer, health care center, third-party

175 administrator or exempt insurer subject to this subsection to produce
176 the records in its possession, and may require any other person to
177 produce the records in such person's possession, that were used to
178 prepare such report, for said commissioner's or said commissioner's
179 designee's examination. If said commissioner determines there is other
180 than a good faith discrepancy between the actual number of insured or
181 enrolled lives that should have been reported under subdivision (3) of
182 this subsection and the number actually reported, such insurer, health
183 care center, third-party administrator or exempt insurer shall pay a
184 civil penalty of not more than fifteen thousand dollars for each report
185 filed for which said commissioner determines there is such a
186 discrepancy.

187 (7) (A) The Insurance Commissioner shall apply an overpayment of
188 the health and welfare fee by an insurer, health care center, third-party
189 administrator or exempt insurer for any fiscal year as a credit against
190 the health and welfare fee due from such insurer, health care center,
191 third-party administrator or exempt insurer for the succeeding fiscal
192 year, subject to an adjustment under subdivision (4) of this subsection,
193 if: (i) The amount of the overpayment exceeds five thousand dollars;
194 and (ii) on or before June first of the calendar year of the overpayment,
195 the insurer, health care center, third-party administrator or exempt
196 insurer (I) notifies the commissioner of the amount of the
197 overpayment, and (II) provides the commissioner with evidence
198 sufficient to prove the amount of the overpayment.

199 (B) Not later than ninety days following receipt of notice and
200 supporting evidence under subparagraph (A) of this subdivision, the
201 commissioner shall (i) determine whether the insurer, health care
202 center, third-party administrator or exempt insurer made an
203 overpayment, and (ii) notify the insurer, health care center, third-party
204 administrator or exempt insurer of such determination.

205 (C) Failure of an insurer, health care center, third-party
206 administrator or exempt insurer to notify the commissioner of the
207 amount of an overpayment within the time prescribed in

208 subparagraph (A) of this subdivision constitutes a waiver of any
209 demand of the insurer, health care center, third-party administrator or
210 exempt insurer against the state on account of such overpayment.

211 (D) Nothing in this subdivision shall be construed to prohibit or
212 limit the right of an insurer, health care center, third-party
213 administrator or exempt insurer to appeal pursuant to subparagraph
214 (B) of subdivision (5) of this section."

This act shall take effect as follows and shall amend the following sections:		
Sec. 501	<i>from passage and applicable to any public health fee due on or after February 1, 2017</i>	19a-7p
Sec. 502	<i>from passage and applicable to any health and welfare fee due on or after February 1, 2017</i>	19a-7j